JACK D. CLIFTON, DDS
STEVENSON DENTAL CARE
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HEALTH HISTORY

NAME	DATE OF BIRTH	AGE	SEX: (CIRCLE) M F

MEDICAL HISTORY

GENERAL
Why are you seeking dental treatment now?_____
_____
_____

	YES	NO
Are you in good health now?	❑	❑
Is there any activity your doctor says you should not do?	❑	❑
Tire easily or feel weak?	❑	❑
Night sweats?	❑	❑
Marked weight change?	❑	❑
Height_____ Weight_____		
Use Tobacco?	❑	❑
How much?_____		
Hospitalized for any serious illness?	❑	❑
Do you have an electrical implant, pacemaker, defibrillator, stimulator, transmitter or monitor?	❑	❑
Women: Are you pregnant, trying to become pregnant, nursing, or taking birth control medication?	❑	❑

HAVE YOU HAD OR CURRENTLY EXPERIENCE ANY OF THE FOLLOWING?

	YES	NO
SKIN		
Eruptions (rash/hives)	❑	❑
Latex sensitivity or allergy?	❑	❑
Have you had a change in skin color?	❑	❑
EYES		
Vision change	❑	❑
Glaucoma	❑	❑
EARS		
Hearing Loss (recent)	❑	❑
Ringing in ears	❑	❑
Pain in or by ear(s)	❑	❑
NOSE		
Frequent nosebleeds	❑	❑
THROAT		
Soreness/hoarseness	❑	❑
RESPIRATORY		
Difficulty breathing	❑	❑
Asthma or allergies	❑	❑
Bronchitis	❑	❑
Emphysema	❑	❑
Persistent cough	❑	❑
Sputum production (phlegm)	❑	❑
Cough up bloody sputum	❑	❑
Tuberculosis	❑	❑
ENDOCRINE		
Diabetes	❑	❑
Family history of Diabetes	❑	❑
Thyroid condition	❑	❑
Goiter	❑	❑
Other_____	❑	❑
NERVOUS SYSTEM		
Stroke	❑	❑
Headaches	❑	❑
Convulsions/epilepsy	❑	❑
Numbness/tingling	❑	❑
Dizziness/fainting	❑	❑
HEART/BLOOD VESSELS		
High blood pressure	❑	❑
Shortness of breath	❑	❑
Swelling of ankles	❑	❑
Heart attack, Heart Surgery, or Heart Disease	❑	❑
Pacemaker or Defibrillator	❑	❑
Chest pain/discomfort	❑	❑
Stents placed in arteries	❑	❑
Serious heart infection requiring hospitalization (endocarditis)	❑	❑
Born with any heart defects	❑	❑
Artificial heart valve	❑	❑
Heart Transplant	❑	❑
Stroke	❑	❑
BLOOD		
Bleeding tendency	❑	❑
Excessive bleeding following tooth extraction	❑	❑
Bruise easily	❑	❑
Anemia	❑	❑
Sickle Cell disease	❑	❑
Other_____	❑	❑
BONE/MUSCLES		
Artificial joints	❑	❑
Osteoporosis medications taken past or present?	❑	❑
Arthritis/rheumatism	❑	❑
DIGESTIVE SYSTEM		
Acid reflux/Heart Burn/GERD	❑	❑
Ulcers	❑	❑
Colitis/diverticulitis/ irritable bowel syndrome	❑	❑
URINARY		
Kidney disease	❑	❑
Increase in frequency of urination at night	❑	❑
Burning on urination	❑	❑
Urethral discharge	❑	❑
Bloody urine	❑	❑
Venereal disease	❑	❑
Syphilis	❑	❑
AIDS or ARC (AIDS Related Complex)	❑	❑
LIVER		
Hepatitis	❑	❑
Cirrhosis	❑	❑
Other liver disease or condition	❑	❑
CANCER OR BENIGN TUMOR OR GROWTH	❑	❑

MEDICATIONS

ALLERGIES OR REACTIONS TO:	YES	NO
Local Anesthetic	❑	❑
Penicillin	❑	❑
Antibiotics, Any	❑	❑
Sulfa drugs	❑	❑
Aspirin or Codeine	❑	❑
Barbiturates, sedatives, sleeping pills	❑	❑
Latex	❑	❑
Jewelry or metals	❑	❑
Foods, specify	❑	❑
Other	❑	❑

MEDICATIONS - ARE YOU TAKING ANY OF THE FOLLOWING?	YES	NO
Birth Control medication	❑	❑
Hormone Replacement	❑	❑
Osteoporosis medications, Bisphosphonates	❑	❑
Antacids, Tagamet (Cimetidine)	❑	❑
Antibiotics or Sulfa drugs	❑	❑
Blood Pressure Medication	❑	❑

CURRENT MEDS. CONT.	YES	NO
Blood Thinners, Digitalis/Waferin or other heart medication	❑	❑
Aspirin	❑	❑
Nitroglycerin	❑	❑
Thyroid Medication	❑	❑
Cortisone/steroids	❑	❑
Recreational drugs	❑	❑
Antihistamines/allergry drugs/ cold remedies	❑	❑
Tranquilizers	❑	❑
Barbiturates	❑	❑
Insulin/diabetes medications	❑	❑
Phenytoin (Dilantin)	❑	❑
Vitamins or Supplements	❑	❑
St. John's Wort	❑	❑
Grapefruit, Juice, or extract	❑	❑
Other_____		
How Much_____		

List name of medication and dosage below:	Dosage & Frequency
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

MEDICAL HISTORY (continued)

Sugar in your diet: ❑ none ❑ slight ❑ moderate ❑ high

Any additional disease, problem, condition, or health concern you have not advised us of? _____

Who is/are your regular physician(s) or specialist(s)? _____

DENTAL HISTORY

Have you ever had any of the following?

MOUTH & FACE	YES	NO
Clicking/popping jaw	❑	❑
Difficulty closing/opening jaw	❑	❑
Painful muscles of face, jaw, temple	❑	❑
Pain in or near ears	❑	❑
Jaw surgery	❑	❑
Broken jaw	❑	❑
Orthodontic treatment/braces	❑	❑
Bleeding/sore gums	❑	❑
Unpleasant taste/bad breath	❑	❑
Burning tongue/lips/mouth	❑	❑
Frequent blisters on lips or tongue	❑	❑

TEETH	YES	NO
Loose teeth	❑	❑
Sensitive to hot/cold/sweets	❑	❑
Pain with biting/chewing	❑	❑
Food traps or impaction	❑	❑
Clenching/grinding	❑	❑
Shifting teeth	❑	❑
Change in bite	❑	❑
Difficulty chewing	❑	❑

ORAL HYGIENE	YES	NO
Brush	❑	❑
How often _____		
Dental floss	❑	❑
How often _____		
Flouride rinse	❑	❑
Other _____		

Have you ever been treated for Gum Disease? ❑ YES ❑ NO When? _____

Date of last dental visit? _____ Cleaning? _____ X-rays? _____

Does dental treatment make you nervous? ❑ No ❑ Slight ❑ Moderate ❑ Extreme

Do you prefer/need sedation/relaxation aids for routine or extensive dental care? ❑ YES ❑ NO

Have you ever had any unfavorable reaction from local anesthetic (Novocaine)? ❑ YES ❑ NO

I attest to the accuracy of the information on both sides of this form:

Signature of patient **X** _____ Date _____
(parent or guardian)

Consent: I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I understand that dental treatment and use of anesthetic agents and medications embodies a certain risk. The more common complications are sensitivity, pain, abscess, infection, pulpal necrosis (tooth death), swelling, bleeding, bruising, and discoloration, temporary or permanent numbness and tingling, nausea, and allergic reactions. I understand that there is no warranty or guarantee as to any result or cure. I understand that I can receive a full recital of any and all possible risks attendant to my care by just asking. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist or my physicians for reasons of consultation, referral, coordination with and/or transfer to additional providers.

Signature of patient **X** _____ Date _____
(parent or guardian)

HEALTH HISTORY UPDATE

Have you had a visit to your physician since your last dental visit? ❑ YES ❑ NO

Have you had a change in your health since your last health history update here? ❑ YES ❑ NO

Do you have any health disease, condition or problem you have not mentioned here? ❑ YES ❑ NO

NOTE CHANGES BELOW	PATIENT SIGNATURE	DATE

PROVIDER NOTES